

C Clinical  
F Core  
A Cohort  
R Registry

Packet A:  
Data Processing Cover Sheet  
(Administrative)

Patient ID:  
Patient Initials:  
Clinical Center:  
Contact Number:  
Date:  
RCID:

*[Research Coordinator Completed]*

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Completed prior to data entry at Intake visit

**CONTACT:**       Contact Number 0: Intake Visit

	Date	Initials	Comment
Review Completed Forms:			
Entry:			

Encryption Number:      \_ \_ \_ \_ \_

[Research Coordinator Completed]

**Inclusion Criteria:**

(Responses to questions 1, 2 and 3 must be "YES" to meet eligibility requirements.)

1. Is the patient HIV-infected as confirmed by lab diagnosis? <sub>1</sub> Yes <sub>0</sub> No
2. Patient receives his/her care at or volunteered for HIV-related studies at one of the UPenn-affiliated hospitals? <sub>1</sub> Yes <sub>0</sub> No
3. Has the patient or parent/legal guardian signed and dated the Informed Consent?  
a. If **YES**, record the date the form was signed. <sub>1</sub> Yes <sub>0</sub> No  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
month day year

**Deferral Criteria:**

(Responses to questions 4 and 5 must be "NO" to meet eligibility requirements.)

4. Does the patient wish to take additional time to consider enrolling in the registry? <sub>1</sub> Yes <sub>0</sub> No
5. Does the patient present an emotional and / or physical state that prohibits him / her from properly considering enrollment in the registry? <sub>1</sub> Yes <sub>0</sub> No
6. Is the patient eligible for the study at this time? <sub>1</sub> Yes <sub>0</sub> No <sub>2</sub> Deferred  
➔ If **YES**, please continue.  
➔ If **Deferred**, please indicate the date of re-assessment.  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
month day year

**Eligibility Confirmation:**

7. Has this patient been fully screened and is now eligible to participate in the CCCR? <sub>1</sub> Yes <sub>0</sub> No <sub>2</sub> Deferred
8. Research Coordinator's signature: \_\_\_\_\_
9. Research Coordinator's ID \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
month day year

C Clinical  
F Core  
A Cohort  
R Registry

Packet A:  
Patient Contact Information

Patient ID:  
Patient Initials:  
Clinical Center:  
Contact Number:  
Date:  
RCID:

[Research Coordinator Completed]

**This form contains confidential information for Clinical Center use only. DO NOT forward to Clinical Core.**

1. Name: \_\_\_\_\_  
LAST FIRST MIDDLE

2. Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Encryption Number generated by the Data Management System is recorded on the Data Processing Cover Sheet (DPCS).

3. Institution Medical Records Number: \_\_\_\_\_

4. Address: \_\_\_\_\_  
STREET ADDRESS

\_\_\_\_\_ CITY STATE ZIP CODE

Mailing address, if different than above:

\_\_\_\_\_ STREET ADDRESS

\_\_\_\_\_ CITY STATE ZIP CODE

5. Home Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(AREA CODE)

6. Work Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(AREA CODE)

7. Cell Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(AREA CODE)

8. eMail Address: \_\_\_\_\_ @ \_\_\_\_\_

9. What is the best way to contact you?  Home  Work  Cell  E-mail

10. What is the best time to contact you? \_\_\_\_\_

11. Who is your usual primary care physician?

Name: \_\_\_\_\_  
LAST FIRST MIDDLE

Address: \_\_\_\_\_  
STREET ADDRESS

\_\_\_\_\_ CITY STATE ZIP CODE

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(AREA CODE)

C Clinical  
F Core  
A Cohort  
R Registry

**Packet A:**  
**Patient Contact Information**

**Patient ID:**

**Contact Number:**

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**Other Contacts (name, address and telephone number of relatives/friends if we cannot contact you directly):**

12. Name: \_\_\_\_\_  
LAST FIRST MIDDLE

Address: \_\_\_\_\_  
STREET ADDRESS

\_\_\_\_\_ CITY STATE ZIP CODE

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(AREA CODE)

Relationship to you: \_\_\_\_\_

13. Is this person aware of your HIV status? <sub>1</sub> Yes <sub>0</sub> No

*Note: Previous Question 13a referring to where a participant obtained their HIV medications has been dropped from this section. To view this question, please refer to an older archived version to view this question.*

For CHOP patients only: If the patient is currently 18 years old or younger AND has had HIV since birth, please complete 14-17.

14. What is your father's first and last name?

\_\_\_\_\_ FIRST NAME LAST NAME

15. What is your father's Social Security Number? \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Encryption Number generated by the Data Management System is recorded on the Data Processing Cover Sheet (DPCS).

16. What is your mother's first and last name?

\_\_\_\_\_ FIRST NAME LAST NAME

17. What is your mother's Social Security Number? \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*Note: Previous Question 18 and subsequent Questions 18a – 18j referring to a participant's children and their demographic information have been dropped from this section, please refer to an older archived version to view these questions.*

[Research Coordinator Completed]

1. What is your date of birth?

\_\_\_ / \_\_\_ / \_\_\_  
month day year

Note: Previous Questions 1a – 1d referring to Parent's DOB and serostatus have been dropped from this section; please refer to an older archived version to view these questions.

2. What is your present gender?

- <sub>1</sub> Male  
<sub>2</sub> Female

- <sub>3</sub> Male living as a female  
<sub>4</sub> Female living as a male

2a. What is your birth gender?

<sub>1</sub> Male

<sub>2</sub> Female

Note: Previous Question 3 referring to an individual's race / ethnic group have been dropped from this section; please refer to an older archived version to view these questions.

3a. Were you born in the United States?

<sub>1</sub> Yes (skip to question #4)

<sub>0</sub> No (go to question #3b)

3b. If **NO**, are you a United States citizen?

<sub>1</sub> Yes

<sub>0</sub> No

4. What is the highest grade of education that you have completed?

- <sub>1</sub> Less than high school graduate  
<sub>2</sub> High school graduate or GED  
<sub>3</sub> Some college

- <sub>4</sub> Graduated from college  
<sub>5</sub> Graduate or professional school after college  
<sub>6</sub> Trade school/Technical school

5. What is your current employment status?

- <sub>1</sub> Employed  
<sub>2</sub> Unemployed  
<sub>3</sub> Student

- <sub>4</sub> Retired  
<sub>5</sub> Disabled

6. What is your current annual gross family income (members living in the same household)?

- <sub>1</sub> \$10,000 or less  
<sub>2</sub> \$10,001 to \$25,000  
<sub>3</sub> \$25,001 to \$50,000

- <sub>4</sub> \$50,001 to \$100,000  
<sub>5</sub> More than \$100,000  
<sub>6</sub> Prefer not to answer

[Research Coordinator Completed]

7. How many children do you have?

— —

(If you have children, please indicate their birth years and HIV status for each below.)

	Initials	Year of Birth (last 2 digits only)	Is this child HIV+?	
7a. Child # 1:	— — —	— —	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
7b. Child # 2:	— — —	— —	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
7c. Child # 3:	— — —	— —	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
7d. Child # 4:	— — —	— —	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
7e. Child # 5:	— — —	— —	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
7f. Child # 6:	— — —	— —	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
7g. Child # 7:	— — —	— —	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
7h. Child # 8:	— — —	— —	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
7i. Child # 9:	— — —	— —	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
7j. Child # 10:	— — —	— —	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No

7k. (For female participants) Are you currently pregnant?

<sub>1</sub> Yes

<sub>0</sub> No

<sub>98</sub> N/A (for male participants)

8. What is your primary current insurance plan?

<sub>1</sub> Fee-for-service/BC/BS

<sub>2</sub> Medicare only

<sub>3</sub> Medicaid only

<sub>4</sub> Medicare and Medicaid

<sub>5</sub> Medicare and supplemental

<sub>6</sub> HMO/POS-BC/BS

<sub>7</sub> Medicare/HMO

<sub>8</sub> Medicaid/HMO

<sub>9</sub> VA/CHAMPUS

<sub>10</sub> PPO

<sub>11</sub> Self-pay

<sub>12</sub> Uninsured

<sub>98</sub> Other

9. What is the first and last name of the provider that you currently see for management of your HIV?

\_\_\_\_\_  
FIRST NAME

\_\_\_\_\_  
LAST NAME

*Note: Previous Question 10a – 10d referring to an individual's Alcohol and Drug Use have been dropped from this section; please refer to an older archived version to view these questions.*

*Note: Previous Question 11 – 14 referring to an individual's Sexual History have been dropped from this section; please refer to an older archived version to view these questions.*

15. What is your ethnicity?

<sub>1</sub> Hispanic or Latino

<sub>2</sub> Not Hispanic or Latino

16. What race do you most identify with?

<sub>1</sub> American Indian / Native Alaskan

<sub>2</sub> Asian

<sub>3</sub> Native Hawaiian / Other Pacific Islander

<sub>4</sub> Black / African American

<sub>5</sub> White / Caucasian

<sub>6</sub> Multiracial

<sub>98</sub> Other

[Research Coordinator Completed]

**HIV History**

1. To the best of your knowledge what ~~month~~ and year were you diagnosed with HIV? \_\_\_/\_\_\_-\_\_\_  
~~month~~ year
2. ~~What month~~ and What year do you think you contracted HIV? \_\_\_/\_\_\_-\_\_\_  
~~month~~ year
3. How do you think you contracted HIV?
  - <sub>1</sub> At birth, from mother
  - <sub>2</sub> Sexual activity
  - <sub>3</sub> Drug use/Sharing needles
  - <sub>4</sub> Blood transfusion
  - <sub>88</sub> Unknown
  - <sub>98</sub> Other, please specify \_\_\_\_\_
4. Prior to your HIV positive diagnosis, did you have any HIV tests done that were negative? <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
5. What is your current weight? \_\_\_ lbs
  - 5a. What would you consider your usual body weight? \_\_\_ lbs
6. What is your current height? \_\_ ft.    \_\_ ins.
7. Have you ever been hospitalized for an HIV-related problem? <sub>1</sub> Yes    <sub>0</sub> No

**General History**

8. Have you ever had or do you currently have any of the following?
  - 8a. Cancer (include Kaposi's sarcoma) <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
  - 8b. Cardiac disease/heart problems <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
  - 8c. Central nervous system/brain problems <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
  - 8d. Hepatitis B <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
  - 8e. Hepatitis C <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
  - 8f. Hepatitis, other/type unknown <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
  - 8g. Lipodystrophy Syndrome (~~my body and/or face has changed~~ changes in face/body shape) <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
  - 8h. Orthopedic disease (bone/joint problems) <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
  - 8i. Psychiatric (mental) disease such as depression <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
  - 8j. Cytomegalovirus disease (CMV) <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
  - 8k. Cryptococcal disease <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
  - 8l. Mycobacterium avium intracellulare ("MAC or "(MAI) infection) <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown
  - 8m. Pneumonia <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

[Research Coordinator Completed]

8n. Abnormal Pap Smear (Women Only)

- <sub>1</sub> Yes  
<sub>0</sub> No  
<sub>88</sub> Unknown  
<sub>99</sub> Not Applicable

8o. Sexual Transmitted Disease, such as (includes Herpes, Gonorrhea, Chlamydia, Trichomonas, Syphilis)

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

8o-i. Genital Herpes outbreak

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

8o-ii. Syphilis diagnosis (RPR positive)

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

8o-iii. Genital warts (HPV)

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

8p. Trouble with high blood sugar/diabetes

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

If response to question #8p is **NO** (0), skip to question #8r.

8q. Have you ever or do you now take medication to regulate your high ~~for~~ blood sugar (diabetic medicine)?

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

8r. Shingles (Herpes zoster)

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

8s. Kidney disease

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

8t. Have you ever been diagnosed with Tuberculosis or had a positive skin test (positive PPD)?

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

9. Have you ever had a blood transfusion?

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

10. ~~Have you had~~ Do you have occasional memory loss or difficulty ~~with your thinking~~ concentrating?

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

11. Have you ever had tingling, ~~or~~ numbness, persistent burning or pain in your feet or hands ~~that lasted more than a few minutes~~ or been diagnosed with neuropathy?

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

12. How much help do you need with normal daily activities?

- <sub>1</sub> None  
<sub>2</sub> A little  
<sub>3</sub> Quite a lot  
<sub>4</sub> All

13. Have you ever had high blood pressure?

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

14. Do you have a family history of high blood sugar/diabetes?

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

15. Do you have a family history of heart disease?

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

If **YES**, please answer question #s 15a and 15b.

15a. Was your father/brother diagnosed before the age 55?

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown

15b. Was your mother/sister diagnosed before the age of 65?

- <sub>1</sub> Yes    <sub>0</sub> No    <sub>88</sub> Unknown



[Research Coordinator Completed]

Past Antiviral Treatment(s):

1. Have you ever taken medications for HIV for one month or more?..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown  
If **YES**, please answer question #1a. If **NO**, please skip to question #12.  
1a. Please provide the approximate month and year when..... / .....  
you first started anti-HIV medication. .... month year
2. Have you ever taken a protease inhibitor for more than 7 days? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown  
2a. If **YES**, which ones? (Check all that apply)
- 2a-i. Amprenavir/Fosamprenavir (Agenerase, Lexiva)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 2a-ii. Indinavir (Crixivan)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 2a-iii. Nelfinavir (Viracept)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 2a-iv. Ritonavir (Norvir)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 2a-v. Saquinavir (Invirase, Fortovase)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 2a-vi. Lopinavir/Ritonavir (Kaletra)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 2a-vii. Atazanavir (Reyataz)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 2a-viii. Tipranavir (Aptivus)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 2a-ix. Darunavir (TMC114)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
3. Have you ever taken a non-nucleoside reverse transcriptase inhibitor (NNRTI) for more than 7 days? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown  
3a. If **YES**, which ones? (Check all that apply)
- 3a-i. Delavirdine (Rescriptor)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 3a-ii. Efavirenz (Sustiva)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 3a-iii. Nevirapine (Viramune)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
4. Have you ever taken a nucleoside reverse transcriptase inhibitor (NRTI) or nucleotide reverse transcriptase inhibitor (NtRTI) for more than 7 days? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown  
4a. If **YES**, which ones? (Check all that apply)
- 4a-i. Lamivudine/Zidovudine (Combivir)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 4a-ii. Lamivudine - 3TC (Epivir)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 4a-iii. Zalcitabine - ddC (Hivid)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 4a-iv. Zidovudine - AZT (Retrovir)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 4a-v. Didanosine - ddl (Videx)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 4a-vi. Stavudine - d4T (Zerit)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 4a-vii. Abacavir (Ziagen)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 4a-viii. AZT/3TC/Abacavir (Trizivir)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 4a-ix. Tenofovir (Viread)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 4a-x. Emtricitabine (Emtriva)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 4a-xi. Abacavir/Lamivudine (Epzicom)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
  - 4a-xii. Emtricitabine/Tenofovir (Truvada)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
5. Have you ever interrupted or stopped anti-HIV medications for more than 7 days? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown

*[Research Coordinator Completed]*

**Current Anti-HIV ~~viral~~ Treatment(s):**

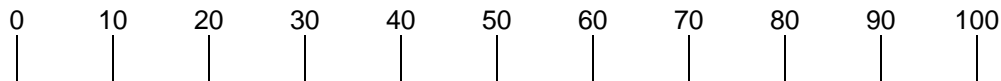
6. Are you currently on HIV medications? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown

If **YES**, continue. If **NO**, do NOT answer question #s 6a, 7, 8 or 9, skip to question #12.

6a. What percent of your anti-HIV medication doses have you taken in the past 30 days?

Please indicate by marking on the scale below. .... %

..... <sub>88</sub> Unknown  
 ..... <sub>97</sub> Not Answered



7. Are you currently on protease inhibitors? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown

7a. If **YES**, which ones? (Check all that apply)

- 7a-i. Amprenavir/Fosamprenavir (Agenerase, Lexiva)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 7a-ii. Indinavir (Crixivan)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 7a-iii. Nelfinavir (Viracept)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 7a-iv. Ritonavir (Norvir) ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 7a-v. Saquinavir (Invirase, Fortovase) ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 7a-vi. Lopinavir/Ritonavir (Kaletra)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 7a-vii. Atazanavir (Reyataz) ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 7a-viii. Tipranavir (Aptivus) ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 7a-ix. Darunavir (TMC114)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown

8. Are you currently on non-nucleoside reverse transcriptase inhibitor (NNRTI)? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown

8a. If **YES**, which ones? (Check all that apply)

- 8a-i. Delavirdine (Rescriptor)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 8a-ii. Efavirenz (Sustiva) ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 8a-iii. Nevirapine (Viramune)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown

9. Are you currently on nucleoside reverse transcriptase inhibitor (NRTI) or nucleotide reverse transcriptase inhibitor (NtRTI)? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown

9a. If **YES**, which ones? (Check all that apply)

- 9a-i. Lamivudine/Zidovudine (Combivir)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 9a-ii. Lamivudine - 3TC (Epivir)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 9a-iii. Zalcitabine - ddC (Hivid)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 9a-iv. Zidovudine - AZT (Retrovir)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 9a-v. Didanosine - ddl (Videx)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 9a-vi. Stavudine - d4T (Zerit)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 9a-vii. Abacavir (Ziagen) ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 9a-viii. AZT/3TC/Abacavir (Trizivir)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 9a-ix. Tenofovir (Viread)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 9a-x. Emtricitabine (Emtriva)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 9a-xi. Abacavir/Lamivudine (Epzicom)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
- 9a-xii. Emtricitabine/Tenofovir (Truvada)..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown

[Research Coordinator Completed]

**Other Antiviral Treatment(s):**

10. Have you ever taken a fusion inhibitor for more than 7 days? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown  
10a. If **YES**, is it/was it Enfuviritide (Fuzeon)?..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
11. Are you currently taking a fusion inhibitor?..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown  
11a. If **YES**, is it Enfuviritide (Fuzeon)? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
12. Are you currently taking alternative/complimentary therapies  
for your HIV? ..... <sub>1</sub> Yes <sub>0</sub> No
13. Are you currently taking any other anti-HIV drug, treatment or  
vaccine (excluding those already listed)? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
14. Are you in a clinical trial/study testing HIV Treatment? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown  
14a. If **YES**, specify: \_\_\_\_\_
15. Have you ever taken a CCR5 inhibitor for more than 7 days? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
16. Are you currently taking a CCR5 inhibitor?..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
17. Have you ever taken an integrase inhibitor for more than 7 days? ..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown
18. Are you currently taking an integrase inhibitor?..... <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown

C Clinical  
F Core  
A Cohort  
R Registry

Packet A:  
Adherence Questions

Patient ID:  
Patient Initials:  
Clinical Center:  
Contact Number:  
Date:  
RC ID:

[Research Coordinator Completed]

1. Where do you get your HIV prescriptions, if any, filled?

Pharmacy name: \_\_\_\_\_

<sub>88</sub> Not available

2. Availability of pharmacy information on index drug:

- <sub>1</sub> Available (proceed to **Adherence Log** below)  
<sub>2</sub> Unavailable (patient is treatment naïve; proceed to **Clinical Laboratory Measures**)  
<sub>88</sub> Unavailable (patient is NOT treatment naïve, but pharmacy information is not available)

**Adherence Log**

Refills	Refill date	Index drug	# of pills per dose	Frequency	# of pills dispensed
				1 = qd 2 = bid 3 = tid 4 = qid 5 = qod	
Last Refill	__/__/____				
Prior Refill 1	__/__/____				
Prior Refill 2	__/__/____				
Prior Refill 3	__/__/____				

[Research Coordinator Completed]

1. Have you received treatment for Hepatitis C? <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown  
(If **No** or **Unknown**, skip to question #2)

1a. Which treatment(s) have you used?

	Ever treated?	Currently treated?
1a-i. Pegylated interferon (once a week)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown
1a-ii. Regular interferon (3 times a week)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown
1a-iii. Ribavirin (Copegus, Virazole, Rebetol)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown

2. Have you received treatment for Hepatitis B? <sub>1</sub> Yes <sub>0</sub> No <sub>88</sub> Unknown  
(If **No** or **Unknown**, skip to **Metabolics**)

2a. Which treatment(s) have you used?

	Ever treated?	Currently treated?
2a-i. Hepsera (Adefovir)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown
2a-ii. Baraclude (Entecavir)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown
2a-iii. Pegylated interferon (once a week)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown
2a-iv. Regular interferon (3 times a week)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown
2a-v. Tyzeka (Telbivudine)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>88</sub> Unknown

[Research Coordinator Completed]

**Metabolics** (for individuals on anti-HIV therapy):

1. Are you currently on anti-HIV therapy? <sub>1</sub> Yes  
<sub>0</sub> No (skip to question #3)
2. Since starting your anti-HIV therapy, have you noticed any of the following?
- 2a. Loss of fat in face? <sub>0</sub> Big loss  
<sub>1</sub> Slight loss  
<sub>2</sub> No change
- 2b. Change in body fat in arms or legs? <sub>0</sub> Big loss  
<sub>1</sub> Slight loss  
<sub>2</sub> No change  
<sub>3</sub> Slight gain  
<sub>4</sub> Big gain
- 2c. Change in body fat in abdomen? <sub>0</sub> Big loss  
<sub>1</sub> Slight loss  
<sub>2</sub> No change  
<sub>3</sub> Slight gain  
<sub>4</sub> Big gain
- 2d. FOR WOMEN, change in breast size? <sub>0</sub> Decrease  
<sub>1</sub> No change  
<sub>2</sub> Increase  
<sub>99</sub> N/A
- 2e. FOR MEN, presence of fatty tissues in chest? <sub>0</sub> Yes  
<sub>1</sub> No  
<sub>99</sub> N/A
3. How many times a week do you exercise for at least 30 minutes? <sub>0</sub> Never  
<sub>1</sub> Once or twice  
<sub>2</sub> 3 to 5 times  
<sub>3</sub> 6 to 7 times

C Clinical  
F Core  
A Cohort  
R Registry

Packet A:  
Clinical Laboratory Measures

Patient ID:  
Patient Initials:  
Clinical Center:  
Contact Number:  
Date:  
RCID:

[Research Coordinator Completed]

**Mental Status (MS) Test:**

1. Thirty (30) second MS test [Alternating numbers and letters] Result: \_\_\_\_\_  
<sub>1</sub> Language Barrier  
<sub>97</sub> Refused
2. Spell "WORLD" backwards: \_\_\_\_\_  
<sub>1</sub> Language Barrier  
<sub>97</sub> Refused

**Laboratory Results:**

- | Pre-treatment: | Date              | Result  |
|----------------|-------------------|---|
| 1. Viral Load  | ___ / ___ / _____ | <input type="checkbox"/> <sub>1</sub> Less than threshold of _____ copies/ml<br><input type="checkbox"/> <sub>2</sub> Actual count recorded as _____ copies/ml<br><input type="checkbox"/> <sub>3</sub> Greater than threshold of _____ copies/ml<br><input type="checkbox"/> <sub>88</sub> Not available |
| 2. CD 4 Count  | ___ / ___ / _____ | _____ ul <input type="checkbox"/> <sub>88</sub> Not available   |

- | Current:                 | Date              | Result  |
|--------------------------|-------------------|---|
| 3. Current Viral Load    | ___ / ___ / _____ | <input type="checkbox"/> <sub>1</sub> Less than threshold of _____ copies/ml<br><input type="checkbox"/> <sub>2</sub> Actual count recorded as _____ copies/ml<br><input type="checkbox"/> <sub>3</sub> Greater than threshold of _____ copies/ml<br><input type="checkbox"/> <sub>88</sub> Not available |
| 4. CD 4 Count            | ___ / ___ / _____ | _____ ul <input type="checkbox"/> <sub>88</sub> Not available   |
| 5. CD 4 Percentage       | ___ / ___ / _____ | _____ % <input type="checkbox"/> <sub>88</sub> Not available  |
| 6. CD 8, absolute number | ___ / ___ / _____ | _____ ul <input type="checkbox"/> <sub>88</sub> Not available   |

7. Have you ever had an HIV resistance test? <sub>1</sub> Yes <sub>0</sub> No
- 7a. If **YES**, when was your most recent HIV resistance test? Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

**[Research Coordinator Completed]**

8. Free testosterone \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ pg/dL <sub>88</sub> Not available
9. Most recent metabolic panel: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_
- 9a. Triglycerides: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ mg/dL <sub>88</sub> Not available
- 9b. Total Cholesterol: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ mg/dL <sub>88</sub> Not available
- 9c. HDL Cholesterol: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ mg/dL <sub>88</sub> Not available
- 9d. LDL Cholesterol: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ mg/dL <sub>88</sub> Not available
- 9e. Glucose: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ mg/dL <sub>88</sub> Not available
10. Most recent hepatic serologies:
- 10a. Anti-HBcAg: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ <sub>1</sub> Positive <sub>0</sub> Negative <sub>88</sub> Not available
- 10b. Anti-HBsAg: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ <sub>1</sub> Positive <sub>0</sub> Negative <sub>88</sub> Not available
- 10c. Anti-HBeAg: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ <sub>1</sub> Positive <sub>0</sub> Negative <sub>88</sub> Not available
- 10d. HBsAg: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ <sub>1</sub> Positive <sub>0</sub> Negative <sub>88</sub> Not available
- 10e. HBeAg: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ <sub>1</sub> Positive <sub>0</sub> Negative <sub>88</sub> Not available
- 10f. HBV DNA level: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ <sub>1</sub> Positive <sub>0</sub> Negative <sub>88</sub> Not available
- 10g. Anti-HCV: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ <sub>1</sub> Reactive <sub>0</sub> Non-reactive <sub>88</sub> Not available
- 10g-i. If **POSITIVE**, HCV genotype: <sub>1</sub> Type 1 <sub>5</sub> Unknown type  
<sub>2</sub> Type 2 <sub>88</sub> Not available  
<sub>3</sub> Type 3 <sub>98</sub> Other  
<sub>4</sub> Type 4
- 10g-ii. If **POSITIVE**, HCV RNA level: \_\_\_\_\_ units <sub>88</sub> Not available



C Clinical  
F Core  
A Cohort  
R Registry

Packet A:  
Biological Specimen

Patient ID:  
Patient Initials:  
Clinical Center:  
Contact Number:  
Date:  
RCID:

*[Research Coordinator Completed]*

1. Was a research blood sample obtained?

<sub>1</sub> Yes      <sub>0</sub> No

1a. If **YES**, date blood sample sent to lab for storage:

\_\_\_ / \_\_\_ / \_\_\_  
month    day    year

[Research Coordinator Completed]

A. Have you ever had a drink containing alcohol (such as beer, wine, or liquor)?

- <sub>1</sub> Yes  
<sub>0</sub> No (skip to question B)

NOTE:

A "drink" is defined as one of the following:

- 1) 12 oz. of beer
- 2) 1.5 oz shot of liquor
- 3) 5 oz. glass of wine

A1. Have you used alcohol in the past 6 months?

- <sub>1</sub> Yes  
<sub>0</sub> No

A2. How often did you have a drink containing alcohol over the last month?

- <sub>0</sub> Never  
<sub>1</sub> Once  
<sub>2</sub> Two to four times a month  
<sub>3</sub> Two to three times per week  
<sub>4</sub> Four or more times a week

A3. How many drinks containing alcohol did you have on a typical day when you were drinking over the last month?

- <sub>0</sub> 0  
<sub>1</sub> 1 or 2  
<sub>2</sub> 3 or 4  
<sub>3</sub> 5 or 6  
<sub>4</sub> 7 – 9  
<sub>5</sub> 10 or more

A4. How often did you have six or more drinks on one occasion over the last month?

- <sub>0</sub> Never  
<sub>1</sub> Less than monthly  
<sub>2</sub> Monthly  
<sub>3</sub> Two or three times per week  
<sub>4</sub> Four or more times per week

B. Have you ever smoked marijuana (pot, weed, joints, or blunts)?

- <sub>1</sub> Yes  
<sub>0</sub> No (skip to question C)

B1. Have you used marijuana in the past 6 months?

- <sub>1</sub> Yes  
<sub>0</sub> No

B2. How often have you used marijuana over the last month?

- <sub>0</sub> Not at all  
<sub>1</sub> Once  
<sub>2</sub> A few times  
<sub>3</sub> A few times a week  
<sub>4</sub> Everyday

[Research Coordinator Completed]

C. Have you ever used cocaine or methamphetamines in any form (including freebasing, speedball, or crack)?

- <sub>1</sub> Yes  
<sub>0</sub> No (skip to question D)

C1. Have you used cocaine in the past 6 months?

- <sub>1</sub> Yes  
<sub>0</sub> No

C2. How often have you used cocaine over the last month?

- <sub>0</sub> Not at all  
<sub>1</sub> A few times  
<sub>2</sub> A few times a week  
<sub>3</sub> Everyday

C3. Have you used methamphetamines in the past 6 months?

- <sub>1</sub> Yes  
<sub>0</sub> No

C4. How often have you used methamphetamines over the last month?

- <sub>0</sub> Not at all  
<sub>1</sub> A few times  
<sub>2</sub> A few times a week  
<sub>3</sub> Everyday

D. Have you ever used heroin?

- <sub>1</sub> Yes  
<sub>0</sub> No (skip to question E)

D1. Have you used heroin in the past 6 months?

- <sub>1</sub> Yes  
<sub>0</sub> No

D2. How often have you used heroin over the last month?

- <sub>0</sub> Not at all  
<sub>1</sub> A few times  
<sub>2</sub> A few times a week  
<sub>3</sub> Everyday

[Research Coordinator Completed]

**Original CFAR ALCADD Section E. Archived.**  
**Please do not complete Questions E, E1, or E2.**  
**Please proceed to Question E3 below.**

E. Have you ever used pills in a non-prescribed way to get high, relax, kill pain, or go to sleep (such as Xanax, Ecstasy, Vicodin, Percocets, Oxycotin)?

- <sub>1</sub> Yes  
<sub>0</sub> No (skip to question F)

E1. Have you used pills to get high, relax, kill pain, or sleep in the past 6 months?

- <sub>1</sub> Yes  
<sub>0</sub> No

E2. How often have you used pills to get high, relax, kill pain, or sleep over the last month?

- <sub>0</sub> Not at all  
<sub>1</sub> A few times  
<sub>2</sub> A few times a week  
<sub>3</sub> Everyday

**ALCADD Section E updates per REDCap Survey.**  
**Please begin Section E with Question E3 below:**

E3. Have you ever used pills in a non-prescribed way to get high, relax, kill pain, or go to sleep?

Examples include: ambien, zolpidem, downers, xanax, zannys, ecstasy, benzos, lorazepam, klonopin, klonnies, valium, oxycontin, oxies, percs, percocet, vikes, vicodin, ativan

- <sub>1</sub> Yes  
<sub>0</sub> No (skip to question F)

E3a. If yes, which of the following categories of drugs have you used not as prescribed?  
**(Check all that apply)**

- <sub>1</sub> Painkillers  
(**vicodin, vikes, percocet, percs, oxies, oxycontin, hydrocodone**)
- <sub>1</sub> Hypnotics- frequently used as sleeping pills  
(**ambien, lunesta, zolpidem, zaleplon**)
- <sub>1</sub> Benzodiazepines aka benzos  
(**xanax, zannys, ativan, klonopin, valium, diazepam, lorazepam**)
- <sub>1</sub> MDMA  
(**ecstasy tablet**)

E3b1. Have you used these pain pills (**vicodin, vikes, percocet, percs, oxies, oxycontin, hydrocodone**) to get high, relax, kill pain, or sleep in the past 6 months?

- <sub>1</sub> Yes  
<sub>0</sub> No

E3b2. How often have you used these pain pills (**vicodin, vikes, percocet, percs, oxies, oxycontin, hydrocodone**) to get high, relax, kill pain, or sleep over the last month?

- <sub>0</sub> Not at all  
<sub>1</sub> A few times  
<sub>2</sub> A few times a week  
<sub>3</sub> Everyday

[Research Coordinator Completed]

E3c1. Have you used these hypnotic pills (**ambien, lunesta, zolpidem, zaleplon**) to get high, relax, kill pain, or sleep in the past 6 months?

- <sub>1</sub> Yes  
<sub>0</sub> No

E3c2. How often have you used these hypnotic pills (**ambien, lunesta, zolpidem, zaleplon**) to get high, relax, kill pain, or sleep over the last month?

- <sub>0</sub> Not at all  
<sub>1</sub> A few times  
<sub>2</sub> A few times a week  
<sub>3</sub> Everyday

E3d1. Have you used these benzodiazepines pills (**xanax, zannys, ativan, klonopin, valium, diazepam, lorazepam**) to get high, relax, kill pain, or sleep in the past 6 months?

- <sub>1</sub> Yes  
<sub>0</sub> No

E3d2. How often have you used these benzodiazepines pills (**xanax, zannys, ativan, klonopin, valium, diazepam, lorazepam**) to get high, relax, kill pain, or sleep over the last month?

- <sub>0</sub> Not at all  
<sub>1</sub> A few times  
<sub>2</sub> A few times a week  
<sub>3</sub> Everyday

E3e1. Have you used MDMA/ecstasy pills to get high, relax, kill pain, or sleep in the past 6 months?

- <sub>1</sub> Yes  
<sub>0</sub> No

E3e2. How often have you used MDMA/ecstasy pills to get high, relax, kill pain, or sleep over the last month?

- <sub>0</sub> Not at all  
<sub>1</sub> A few times  
<sub>2</sub> A few times a week  
<sub>3</sub> Everyday

[Research Coordinator Completed]

F. Have you ever smoked cigarettes or used other nicotine products (chewing tobacco, cigars, pipes)?

- <sub>1</sub> Yes  
<sub>0</sub> No (skip to question G)

F1. Have you smoked cigarettes/used tobacco products in the past 6 months?

- <sub>1</sub> Yes  
<sub>0</sub> No

F2. How often have you smoked cigarettes/used tobacco products over the last month?

- <sub>0</sub> Not at all  
<sub>1</sub> A few times  
<sub>2</sub> A few times a week  
<sub>3</sub> Everyday

G. Have you ever been in treatment for drug or alcohol problems (treatment includes inpatient, outpatient, detox, residential programs, etc.)?

- <sub>1</sub> Yes  
<sub>0</sub> No

H. Have you ever injected any drugs?

- <sub>1</sub> Yes  
<sub>0</sub> No (skip to question I)

H1. How old were you when you first injected drugs?

\_\_\_\_\_ years

H2. In the past 6 months, how often have you injected any drugs?

- <sub>0</sub> Not at all (skip to question I)  
<sub>1</sub> A few times  
<sub>2</sub> A few times a week  
<sub>3</sub> Everyday

H3. In the past 6 months, how often did you share needles or works?

- <sub>0</sub> Not at all  
<sub>1</sub> A few times  
<sub>2</sub> A few times a week  
<sub>3</sub> Everyday

I. Has a psychologist, therapist, doctor, or other clinician ever told you that you were depressed, schizophrenic, or bipolar?

- <sub>1</sub> Yes  
<sub>0</sub> No (skip to Sexual History questions)

I1. Have you received any medications to treat your mental condition in the past 6 months?

- <sub>1</sub> Yes

Please specify: \_\_\_\_\_

- <sub>0</sub> No

[Research Coordinator Completed]

1. Do you consider yourself:

- <sub>1</sub> Gay / Lesbian
- <sub>2</sub> Straight / Heterosexual
- <sub>3</sub> Bisexual
- <sub>98</sub> Other

2. Have you ever had anal, vaginal or oral sex?

- <sub>1</sub> Yes
- <sub>0</sub> No

If **NO**, skip to Depression Screen (**CES\_D**). If **YES**, continue.

3. Approximately how many sexual partners have you had in your lifetime?

-----

4. Approximately how many partners have you had in the past 6 months?

-----

5. Do you have a regular sex partner?

- <sub>1</sub> Yes
- <sub>0</sub> No (skip to question 8)

6. Is your regular sex partner HIV Positive?

- <sub>1</sub> Yes
- <sub>0</sub> No
- <sub>88</sub> Don't Know

7. Approximately how often do you and your regular sex partner use condoms?

- <sub>0</sub> Never
- <sub>1</sub> Some of the time
- <sub>2</sub> Most of the time
- <sub>3</sub> All the time

8. Have you had sex with anyone (other than your regular sex partner) in the past 6 months?  
(If **YES**, answer question 9. If **NO**, skip to question 10.)

- <sub>1</sub> Yes
- <sub>0</sub> No
- <sub>99</sub> Have not had sex in the past 6 months

9. Approximately how often do you and your other sex partner(s) use condoms?

- <sub>0</sub> Never
- <sub>1</sub> Some of the time
- <sub>2</sub> Most of the time
- <sub>3</sub> All the time

10. How often do you disclose your HIV status to your sexual partners?

- <sub>0</sub> Never
- <sub>1</sub> Some of the time
- <sub>2</sub> Most of the time
- <sub>3</sub> All the time

[Research Coordinator Completed]

11. Have you ever given or received money or drugs for sex?

- <sub>0</sub> Never <sub>2</sub> A few times each month  
<sub>1</sub> A few times or less <sub>3</sub> A few times each week

12. Have you ever used substances to enhance your sexual performance or pleasure (substances may include Viagra, Cialis, Levitra, testosterone replacement therapy, etc)?

- <sub>0</sub> Never (skip to question #14) <sub>3</sub> A few times each week  
<sub>1</sub> A few times or less <sub>99</sub> Not applicable (for females)  
<sub>2</sub> A few times each month

13. Were these sexually enhancing substances prescribed by a doctor or a clinician?

- <sub>1</sub> Yes <sub>0</sub> No

**Column ONE**

**Column TWO**

14. Have you ever had vaginal sex?

- <sub>1</sub> Yes  
<sub>0</sub> No (skip to column TWO)

20. Have you ever had anal sex?

- <sub>1</sub> Yes  
<sub>0</sub> No (skip to **CES\_D**)

15. With how many people have you had vaginal sex in the past 6 months?

- <sub>0</sub> 0 (skip to column TWO)  
<sub>1</sub> 1  
<sub>2</sub> Other \_\_\_\_ (fill in blank)

21. With how many people have you had anal sex in the past 6 months?

- <sub>0</sub> 0 (skip to depression screen)  
<sub>1</sub> 1  
<sub>2</sub> Other \_\_\_\_ (fill in blank)

16. How often have you had vaginal sex in the past 6 months?

- <sub>1</sub> A few times or less  
<sub>2</sub> A few times each month  
<sub>3</sub> A few times each week

22. How often have you had anal sex in the past 6 months?

- <sub>1</sub> A few times or less  
<sub>2</sub> A few times each month  
<sub>3</sub> A few times each week

17. In the past 6 months, how often have you had vaginal sex with someone whose HIV status you did not know?

- <sub>0</sub> Never  
<sub>1</sub> A few times or less  
<sub>2</sub> A few times each month  
<sub>3</sub> A few times each week

23. In the past 6 months, how often have you had anal sex with someone whose HIV status you did not know?

- <sub>0</sub> Never  
<sub>1</sub> A few times or less  
<sub>2</sub> A few times each month  
<sub>3</sub> A few times each week



C Clinical  
F Core  
A Cohort  
R Registry

Packet A:  
Sexual History Addendum

Patient ID:  
Patient Initials:  
Clinical Center:  
Contact Number:  
Date:  
RCID:

[Research Coordinator Completed]

<p>18. <u>In the past 6 months</u>, how often have you had vaginal sex with someone who was HIV-positive?</p> <p><input type="checkbox"/><sub>0</sub> Never <input type="checkbox"/><sub>1</sub> A few times or less <input type="checkbox"/><sub>2</sub> A few times each month <input type="checkbox"/><sub>3</sub> A few times each week <input type="checkbox"/><sub>88</sub> Unknown</p>	<p>24. <u>In the past 6 months</u>, how often have you had anal sex with someone who was HIV-positive?</p> <p><input type="checkbox"/><sub>0</sub> Never <input type="checkbox"/><sub>1</sub> A few times or less <input type="checkbox"/><sub>2</sub> A few times each month <input type="checkbox"/><sub>3</sub> A few times each week <input type="checkbox"/><sub>88</sub> Unknown</p>
<p>19. <u>In the past 6 months</u> how often did you use condoms when you had vaginal sex?</p> <p><input type="checkbox"/><sub>0</sub> Never <input type="checkbox"/><sub>1</sub> Some of the time <input type="checkbox"/><sub>2</sub> Most of the time <input type="checkbox"/><sub>3</sub> All the time <input type="checkbox"/><sub>88</sub> Unknown</p>	<p>25. <u>In the past 6 months</u>, how often did you use condoms when you had anal sex?</p> <p><input type="checkbox"/><sub>0</sub> Never <input type="checkbox"/><sub>1</sub> Some of the time <input type="checkbox"/><sub>2</sub> Most of the time <input type="checkbox"/><sub>3</sub> All the time <input type="checkbox"/><sub>88</sub> Unknown</p>

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Below is a list of some of the ways you may have felt or behaved over the past week. Please indicate how often you have felt this way during the past week by checking the appropriate response.

	Rarely or none of the time	Some or little of the time	Occasionally or a moderate amount of time	Most or all of the time
1. I was bothered by things that usually don't bother me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. I did not feel like eating; my appetite was poor.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. I felt that I could not shake off the blues even with help from my family or friends.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. I felt that I was just as good as other people.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. I had trouble keeping my mind on what I was doing.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. I felt depressed.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. I felt that everything I did was an effort.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. I felt hopeful about the future.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9. I thought my life had been a failure.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10. I felt fearful.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
11. My sleep was restless.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
12. I was happy.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
13. I talked less than usual.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
14. I felt lonely.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
15. People were unfriendly.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
16. I enjoyed life.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
17. I had crying spells.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
18. I felt sad.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
19. I felt that people dislike me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
20. I could not get "going."	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

C Clinical  
 F Core  
 A Cohort  
 R Registry

Packet A:  
 Contact Checklist  
 (Administrative)

Patient ID:  
 Patient Initials:  
 Clinical Center:  
 Contact Number:  
 Date:  
 RCID:

*[Research Coordinator Completed]*

CRF	Abbreviated Name	Version	Completed
Data Processing Cover Sheet	DPCS		<input type="checkbox"/>
Screening Checklist	SCREEN		<input type="checkbox"/>
Patient Contact Information	PTCTIN		<input type="checkbox"/>
Demographics	DEMO		<input type="checkbox"/>
Medical History	MED		<input type="checkbox"/>
Present and Previous Antiviral Treatments	PRIOR		<input type="checkbox"/>
Adherence Questions	ADHERE		<input type="checkbox"/>
Hepatitis Treatment	HEPTX		<input type="checkbox"/>
Metabolics	METAB		<input type="checkbox"/>
Clinical Laboratory Measures	LAB		<input type="checkbox"/>
Biological Specimen	SERUM		<input type="checkbox"/>
Alcohol and Drug Use Addendum	ALCDADD		<input type="checkbox"/>
Sexual History Addendum	SEXHXADD		<input type="checkbox"/>
CES_D	CES_D		<input type="checkbox"/>
Contact Checklist	CTCK		<input type="checkbox"/>

Specimen sent to Laboratory: <sub>1</sub> Yes <sub>0</sub> No